South Australian Aboriginal Heart and Stroke Plan

Proposed Schedule

Implementation Stage 1: July - Dec 2016
- Establish governance
- Develop full costing and resource requirements for implementation and evaluation
- Obtain funding support for implementation

Implementation Stage 2: Jan 2017 – Dec 2021
- Implementation of the plan as per agreement in Phase 1

The development of the South Australian Aboriginal Heart and Stroke Plan 2017-2021 is funded by SA Health.

Consultation draft prepared by:
Wardliparingga Aboriginal Research Unit, SAHMRI
May 2016
Consultation

Written responses are invited from all interested organisations and individuals.

The consultation will be open until Friday 28 May 2016.

A guide to consultation:

1. The Plan:
   a. Do you have comments on the approach that has been used?
   b. Do you have comments on the framework?
   c. Do you have any specific comments on the plan?

2. Do you have any comments on the:
   a. Background and introduction (pages 6-9)
   b. Strategies for evidence-based, culturally appropriate cardiovascular services (page 17-32)
   c. Essential enablers for effective strategy (page 33-45)

Please send written responses to:
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Supporting documents:
Two supporting documents, which inform the content in this document, are available online at

- Gap analysis and draft recommendations for the SA Aboriginal Heart and Stroke Plan.
- SA Aboriginal Cardiovascular Health Profile.

For more information on the focus and elements of these documents, see page 8.
Acknowledgements

This project is funded by SA Health under Close the Gap.

The project team would like to acknowledge the following organisations and individuals who have contributed to the knowledge in the cardiovascular health profile and the gap analysis (in no particular order):

- Aboriginal community members and Aboriginal Community Reference Group members
- SA Aboriginal Heart and Stroke Plan Steering Committee members
- Aboriginal and Torres Strait Islander Health Branch, SA Health
- Aboriginal Health Council of SA
- Adelaide Primary Health Network
- Apangu Ngangkari Tjutaku Aboriginal Corporation
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Cancer Council
- Close the Gap programs
- Corporate Shuttle
- Country SA Primary Health Network
- Drug and Alcohol Services of South Australia
- Heart Foundation SA
- Heart theme, SAHMRI
- High Blood Pressure Research Council Australia
- Marla Community Health Service
- National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID)
- National Aboriginal Community Controlled Health Organisation
- Northern Health Network
- OPAL
- Royal Flying Doctor Service
- Rural Doctors Workforce Agency
- South Australian Rheumatic Heart Disease Program
- South Australian Health and Medical Research Institute
- Statewide Cardiology Clinical Networks
- Stroke Foundation
- Umoona Aged Care
- Watto Purrunna Aboriginal Health Service

And the following groups:

Aboriginal Community Controlled Health Services:
- Ceduna Koonibba Aboriginal Health Service
- Kalparrin Community
- Nunyara Aboriginal Health Service
- Nganampa Health Council and Mimili clinic
- Nunkuwarrin Yunti
- Oak Valley Health Service
- Pangula Mannamurna, Muna Paiendi
- Pika Wiya Health Service
• Port Lincoln Aboriginal Health Service
• Tullawon Health Service
• Umoona Tjutagku Health Service Aboriginal Corporation

Aboriginal Liaison Units from the following hospitals:
• Flinders Medical Centre (also Repatriation Hospital and Noarlunga Hospital)
• Lyell McEwin Hospital (also Modbury Hospital)
• Royal Adelaide Hospital (Hampstead Centre and The Queen Elizabeth Hospital)
• Women’s and Children’s Hospital
• Port Augusta Hospital

Cardiologists, cardiac surgeons and nurses from the following organisations:
• Flinders Medical Centre
• Lyell McEwin Hospital
• Royal Adelaide Hospital
• The Queen Elizabeth Hospital
• Women’s and Children’s Hospital
• Country Health SA LHN
• Port Augusta Hospital

South Australian Local Health Networks:
• Central Adelaide Local Health Network (LHN)
• Northern Adelaide LHN
• Southern Adelaide LHN
• Women’s and Children’s LHN
• Country Health SA LHN, SA Health
  • Aboriginal Health
  • ICCnet
  • Ceduna District Health Service
  • Central Yorke Peninsula Hospital (Maitland)
  • Coober Pedy Hospital and Health Service
  • Gawler Health Service
  • Mount Gambier Hospital
  • Murray Mallee Community Health Service
  • Port Augusta Hospital and Regional Health Service
  • Port Augusta Step-Down Unit
  • Port Lincoln Hospital and Health Service
  • Port Pirie Regional Health Service
  • Port Pirie GP Plus Health Care Centre
  • Riverland Regional health Services
  • Riverland Community Health Service
  • Whyalla Hospital and Health Service

Stroke specialists from the following organisations:
• Flinders Medical Centre
• Lyell McEwin Hospital
• Royal Adelaide Hospital
• The Queen Elizabeth Hospital
• Women’s and Children’s Hospital

Universities:
• Flinders University
• University of Adelaide
• University of South Australia
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#### Evidence-based, culturally appropriate cardiovascular services

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<tbody>
<tr>
<td>1. Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s</td>
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<tr>
<td>2. Increase the use of cardiovascular risk assessment and management</td>
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<table>
<thead>
<tr>
<th>Clinical suspicion of disease</th>
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<tr>
<td>3. Provide timely access to non-acute diagnostic services to identify and manage disease</td>
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<tr>
<td>4. Establish a coordinated state wide specialist outreach service</td>
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<th>Acute episode care</th>
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<tr>
<td>5. Create awareness of warning signs and symptoms</td>
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<td>6. Improve access to ambulance services through upfront reduction of out-of-pocket cost</td>
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<tr>
<td>7. Improve identification of Aboriginal or Torres Strait Islander status at the first point of medical contact</td>
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<tr>
<td>8. Develop and implement an Aboriginal and Torres Strait Islander transfer and retrieval services protocol</td>
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9a: Maintain and expand coordinated regional system of care from first medical contact to definitive care for acute HEART disease  
9b. Maintain and expand coordinated regional system of care from first medical contact to definitive care for STROKE and TIA  
10a. Develop RAH, FMC, LMH, TQEH, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal HEART clinical and cultural care  
10b. Develop RAH, FMC, LMH, Berri, Mount Gambier, Whyalla, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal STROKE clinical and cultural care  
11. Establish an Aboriginal heart and stroke nursing coordinator position at RAH, FMC, LMH, Port Augusta Hospital and Ceduna Hospital to support Aboriginal patients and their families throughout their journey of care  
12. Develop standard reporting across the state against key performance indicators

<table>
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<tr>
<th>Ongoing care</th>
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<tr>
<td>13. Improve access to culturally appropriate comprehensive primary health care services</td>
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<tr>
<td>14. Develop central referral service that links with primary care, specialist follow-up and cardiac/stroke rehabilitation</td>
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<tr>
<td>15. Establish culturally appropriate, evidence based cardiac and stroke rehabilitation services</td>
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<th>Spanning the continuum of care</th>
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<tr>
<td>16. Improve access to comprehensive primary health care services</td>
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<tr>
<td>17. Develop a state-wide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks. Port Augusta should host a regional coordination centre that coordinates and enhances services for Aboriginal people in the far north and west of SA</td>
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<tr>
<td>18. Maintain and expand of the existing RHD Control Program</td>
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<th>Essential enablers for effective strategy implementation</th>
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<tr>
<td>Governance and systems coordination</td>
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<tr>
<td>1. Develop an SA Aboriginal Heart and Stroke Plan leadership group</td>
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<td>Sustainable funding</td>
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<tr>
<td>2. Develop a business case and funding proposal for the Plan</td>
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<td>3. Improve uptake and efficiency of already funded initiatives</td>
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<td>4. Commitment to writing into agreements sustainable program and evaluation funding</td>
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<td>Workforce development</td>
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<td>7. Improve access to workforce in western and northern Adelaide, and the far west and north of South Australia</td>
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<td>8. Increase awareness of health professionals about the extent and impact heart disease and stroke</td>
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<td>Transport support</td>
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<td>9. Develop model of care for patients from country SA who have transfers or retrieval to Adelaide to be returned to the referral hospital as an in-patient</td>
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<td>10. Review out-of-hospital transport support services across SA, across the continuum of care</td>
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<td>Information and communications technology solutions</td>
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<td>11. Identify successful technologies and integrate into models of care</td>
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<td>12. Support linkages between health records across sectors</td>
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<tr>
<td>Monitoring and evaluation</td>
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<td>13. Develop ongoing monitoring of all aspects of the Plan</td>
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>ACEM</td>
<td>Australian College of Emergency Medicine</td>
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<tr>
<td>ACN</td>
<td>Australian College of Nursing</td>
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<tr>
<td>ACNC</td>
<td>Australian Cardiovascular Nursing College</td>
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<tr>
<td>ACSQHC</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
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<tr>
<td>AHCSA</td>
<td>Aboriginal Health Council of SA</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>ALU</td>
<td>Aboriginal Liaison Unit</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<td>APA</td>
<td>Australian Physiotherapy Association</td>
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<tr>
<td>ARF</td>
<td>Acute rheumatic fever</td>
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<tr>
<td>BCC</td>
<td>Better Cardiac Care for Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td>BPG</td>
<td>Benzathine penicillin G</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
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<td>CSANZ</td>
<td>Cardiac Society of Australia and New Zealand</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>ESSENCE</td>
<td>Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>iCCnet</td>
<td>Integrated Cardiovascular Clinical Network</td>
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<tr>
<td>LHN</td>
<td>Local Health Network</td>
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<tr>
<td>nKPI</td>
<td>National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care</td>
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<td>NSQHSS</td>
<td>National Safety and Quality Health Service Standards</td>
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<tr>
<td>NVDPA</td>
<td>National Vascular Disease Prevention Alliance</td>
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<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<td>PATS</td>
<td>Patient Assistance Transport Scheme</td>
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<td>PBS</td>
<td>Pharmaceuticals Benefits Scheme</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHN</td>
<td>Primary Health Network</td>
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<tr>
<td>POCT</td>
<td>Point of care testing</td>
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<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<td>RAH</td>
<td>Royal Adelaide Hospital</td>
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<td>RDFS</td>
<td>Royal Flying Doctors Service</td>
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<tr>
<td>RDWA</td>
<td>Rural Doctors Workforce Agency</td>
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<tr>
<td>RHD</td>
<td>Rheumatic heart disease</td>
</tr>
<tr>
<td>SAAHP</td>
<td>SA Aboriginal Health Partnership</td>
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<tr>
<td>SAAS</td>
<td>SA Ambulance Service</td>
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<tr>
<td>SA Centre</td>
<td>SA Academic Health Science and Translation Centre</td>
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<td>SSA</td>
<td>Stroke Society of Australasia</td>
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<td>TH</td>
<td>Transforming Health</td>
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<td>TIA</td>
<td>Transient ischaemic attack</td>
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<tr>
<td>WHO</td>
<td>World Health Organisations</td>
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Background to development of the SA Aboriginal Heart and Stroke Plan

Background:
Since 2009 in South Australia there have been a variety of activities focussed on cardiovascular disparities as experienced by Aboriginal people with the aim of reducing inequalities in accessing care. Despite the efforts of a range of committed organisations and individuals, there remains a lack of coherence, coordination and coverage of heart and stroke care for Aboriginal people across the State. As a result poor cardiovascular outcomes for Aboriginal people continue to be experienced.

In early 2015 the Wardliparingga Aboriginal Research Unit was commissioned by SA Health to develop a state-wide plan to guide service development and the reorientation of services to improve cardiovascular care and outcomes for Aboriginal people over the next five years. This project was SA Health’s response to Australian Health Ministers Advisory Committee (AHMAC) request for all Australian states to deliver against the national “Better Cardiac Care for Aboriginal and Torres Strait Islander People 2014” (BCC) framework. (See page #)

The Wardliparingga Aboriginal Research Unit, within the South Australian Health and Medical Research Institute (SAHMRI), has a mission to conduct research that is of direct relevance to Aboriginal people in South Australia. All research is focused on reducing the significant gap between the health status and life opportunities available to Aboriginal people when compared to other Australians. Wardliparingga’s goal is to generate positive, long-term change for Aboriginal families and communities in South Australia.

Development of the SA Aboriginal Heart and Stroke Plan to date:
At the commencement of this project a Steering Committee consisting of key organisations, clinicians and policy makers was established. Professor Alex Brown, the lead of Wardliparingga, chairs the Steering Committee. A Community Reference Group was set up that included members of the Aboriginal community with “lived experience” of cardiovascular disease. Two members of the Community Reference Group represented this group on the Steering Committee.

The project involved three distinct phases (see figure 1):

- **Phase 1** - Understanding the cardiovascular health profile of Aboriginal people in South Australia, including demographic profile, presence of risk and disease, service availability, and service activity.
- **Phase 2** - Undertaking a gap analysis of the provision of evidence-based, culturally appropriate services against need, as defined by community, service providers and policy makers. This was informed by the cardiovascular health profile developed in Phase 1.
- **Phase 3** – Developing a state-wide Aboriginal Heart and Stroke Plan, based on the knowledge from phases 1 and 2.

Throughout the project there has been consultation with staff in a range of government departments, community members, non-government organisations, clinicians, service providers and policy makers. This has enabled a robust understanding of the current state and national policy context of implementing a plan such as this within South Australia. There have been two roundtable stakeholder forums, which have brought together all stakeholders to develop the plan. A full list of people who have been involved in discussions on the plan to date is provided in the acknowledgements.
Figure 1: Phased approach to the development of the SA Aboriginal Heart and Stroke Plan
What information will be available at 30 June 2016?
The project will be completed on 30 June 2016 with the final plan becoming South Australia’s response to Australian Health Ministers Advisory Council’s (AHMAC) National Better Cardiac Care for Aboriginal and Torres Strait Islander project.

There will be 3 distinct documents available at the completion of the project: The SA Aboriginal Cardiovascular Disease Profile 2016, The SA Aboriginal Heart and Stroke Gap Analysis, and The SA Aboriginal Heart and Stroke Plan 2017-2021. See figure for description.

The SA Aboriginal Cardiovascular Disease Profile 2016
The SA Aboriginal Cardiovascular Disease Profile 2016 documents the cardiovascular health of Aboriginal people in SA, the service availability, and service activity. The Profile provides the evidence for the development of the SA Aboriginal Heart and Stroke Gap Analysis and Plan, and provides a baseline for future monitoring and evaluation. The document includes information on demographics, risk factor prevalence, impact of heart disease and stroke, service activity by sector and against national indicators, and patient flow through the system.

The SA Aboriginal Heart and Stroke Gap Analysis
The SA Aboriginal Heart and Stroke Gap Analysis identified gaps in the cardiovascular health care system for Aboriginal clients. The Gap Analysis was informed by the SA Aboriginal cardiovascular disease profile 2016 and extensive consultation with community members, service providers and policy makers. The document provides an overview of the current status, details gaps, and documents draft recommendations.

The SA Aboriginal Heart and Stroke Plan 2017-2021 (this document)
The SA Aboriginal Heart and Stroke Plan 2017-2021 details strategies to improve the heart and stroke care for Aboriginal people in SA and to reduce cardiovascular morbidity and mortality. The Plan includes needs driven, evidence based service provision across the continuum of care and recognises that there are some key enablers that are vital if the services are to be effectively implemented. The Plan has been informed by the Profile and the Gap Analysis.
Introduction - SA Aboriginal Heart and Stroke Plan

Purpose:
To develop a SA Aboriginal Heart and Stroke Plan 2017-2021 to guide the delivery of evidence based services for the prevention and management of those at risk of, and with, cardiovascular disease.

Vision:
To improve cardiovascular care and reduce cardiovascular morbidity and mortality for Aboriginal and Torres Strait Islander Peoples in South Australia.

Targets:
• Reduce the age-standardised mortality rate for cardiovascular conditions.
• Increase identification and management of those at high cardiovascular risk.
• Reduction in 30 day and 12 month unplanned re-hospitalisations following an acute heart or stroke event.

Context:
Of the 37,000 people in South Australia who identify as Aboriginal and/or Torres Strait Islander people, cardiovascular disease accounts for 26% of all deaths and is the leading cause of death for South Australian Aboriginal people.

Aboriginal people experience heart disease and stroke at significantly younger ages than non-Aboriginal South Australians (Figure 2). The greatest disparities exist in the young age groups (25 to 54 years). Aboriginal people are also 60% more likely to be hospitalised for a principal diagnosis of CVD than non-Aboriginal people.

Data source: Cause of Death Unit Record File for South Australia provided by the Australian Coordinating Registry (unpublished) extracted for the SA State of Aboriginal Heart Health Project 30 July 2015

Figure 2: Proportion of deaths from CVD, by Aboriginal status and age, SA 2006-2012
The Framework - SA Aboriginal Heart and Stroke Plan

The SA Aboriginal Heart and Stroke Plan 2017-2021 is driven by a framework with three elements (see figure 3).

1. Patients, family and community
2. Evidence-based, culturally appropriate cardiovascular services
3. Essential enablers for effective strategy implementation

1. Patients, family and community

The individual, their family and community must be positioned at the centre of all stages of care. A holistic approach should acknowledge the physical, social, emotional and cultural aspects which make up wellbeing and ensure that all aspects of wellbeing are considered during diagnosis, treatment, management and ongoing care.

2. Evidence-based, culturally appropriate cardiovascular services

Evidence-based cardiovascular services, provided in a culturally appropriate way, should be accessible to all Aboriginal people in South Australia across the continuum of care. For the purpose of this plan, the continuum of care has been separated into 4 stages, with each stage split into two service groups.

**Stage 1: Primary preventive care**

**Definition** - Promotion of healthy lifestyles, of prevention disease, and assessment and management of risk and early disease as part of comprehensive primary health care.

- **Service group 1a** - Health promotion and disease prevention services
- **Service group 1b** - Risk assessment and management services

**Stage 2: Clinical suspicion of disease**

**Definition** - Timely diagnosis of heart disease and associated risk factors and access to specialist services and services support by specialists as close to the individual’s home as possible.

- **Service group 2a** - Diagnostic investigation services
- **Service group 2b** - Specialist services

**Stage 3: Acute episode**

**Definition** - Equitable access to the best and most reliable acute health care possible, which delivers high quality, well configured, patient centred services in hospital.

- **Service group 3a** - Planned and urgent transfers, and emergency retrieval services
- **Service group 3b** - Acute hospital services

**Stage 4: Ongoing care**

**Definition** - Optimisation of transitions of care out of hospital, rehabilitation, and the provision of ongoing preventive care.

- **Service group 4a** - Hospital discharge planning and follow-up services
- **Service group 4b** - Rehabilitation, secondary prevention and ongoing care services

There is an additional section that refers to strategies for services that span the continuum of care.
3. Essential enablers for effective strategy implementation

The essential enablers identified in the plan are critical to facilitate the effective delivery evidence-based, culturally appropriate cardiovascular services. They span across the health care system and are often outside the direct responsibility of cardiovascular services.

There are 6 essential enablers.

- **Governance and systems co-ordination:**
  A wide range of steering and rule-making related functions to achieve set policy objectives. Governance involves collaboration across sectors to promote and maintain health (WHO, 2016). A governance group should guide implementation and ensure accountability to the South Australian Aboriginal community.

- **Sustainable funding:**
  The availability of adequate, long-term funding of the health system to deliver safe, effective, efficient care in an ongoing and reliable manner.

- **Workforce development:**
  The provision of a health workforce, mainstream and Aboriginal, which has the clinical and cultural competence to provide safe, evidence based care to patients.

- **Transport support:**
  Provision of appropriate and timely transport for Aboriginal people experiencing socio-economic disadvantage to ensure safe access care.

- **Information and communications technology solutions:**
  The application of organised knowledge and skills, including devices, procedures and systems, to solve a health problem and improve quality of lives.

- **Monitoring and evaluation:**
  The ongoing review and analysis of progress towards achieving the objectives set against a reliable and explicit baseline.
Figure 3: Framework of the SA Aboriginal Heart and Stroke Plan 2017-2021
How was the framework developed?

The SA Aboriginal Heart and Stroke Plan framework is based on the national “Better Cardiac Care for Aboriginal and Torres Strait Islander People 2014” (BCC) framework (figure 4) (AHMAC, 2014).

The BCC framework was adapted following consultation with community members, service providers, and policy makers. It was consolidated after each of the key stakeholder roundtables and tested with the Steering Committee and Community Reference Group.

![Figure 4: The “Better Cardiac Care for Aboriginal and Torres Strait Islander People 2014” framework](image)

As a result of this process the BCC framework has been significantly modified for the purpose of the SA Heart and Stroke plan. Modifications include:

- The expansion from cardiac to all cardiovascular disease, including stroke and transient ischaemic attack.
- The addition of essential ‘enablers’ to facilitate the effective delivery of services.
- The broadened definitions of the ‘stages of care’.
- The identification of the service groups under each stage of care.
- The incorporation of rheumatic heart disease across the continuum of the ‘stages of care’.
- The incorporation of “population health promotion”, “health literacy” and “lifestyle modification” across the continuum of the ‘stages of care’.
- Incorporation of “cultural competency” into the workforce development component of essential ‘enablers’.

At the end of this document there is a matrix that maps all the Strategies and Enablers in the Plan against the Better Cardiac Care Actions and Measures.
What does it mean for services to be culturally appropriate?

All care provided by services for Aboriginal and Torres Strait Islander people should be conducted in a manner which is tailored to the individual, is respectful and culturally appropriate, and which takes account of their particular circumstances.

Health services are inappropriate for Aboriginal and Torres Strait Islander people if cultural factors are not acknowledged and respected, or if services are inaccessible to Aboriginal people because they do not meet the health needs prioritised by the community (Bainbridge 2015).

The following features should be included when working to deliver culturally appropriate services:

- Locally defined, culturally safe services
- Appropriately skilled and culturally competent Aboriginal and non-Aboriginal workforce
- Holistic care
- Best practice care
Defining the features of culturally appropriate services

Locally defined, culturally safe services
This includes services that:

- Are built on trusting relationships between healthcare providers, clients and communities.
- Offer culturally welcoming space(s) that treat Aboriginal and Torres Strait Islander clients as human beings with feelings.
- Understand and recognise the cultural diversity of Aboriginal and Torres Strait Islander clients.
- Develop effective listening skills, including observing non verbals such as body language and using reflective listening, to enhance communication and understanding.
- Offer flexible approaches to the delivery of primary healthcare services that can address the complex needs and accommodate the competing demands experienced by many Aboriginal and Torres Strait Islander people.

Appropriately skilled and culturally competent Aboriginal and non-Aboriginal workforce
The workforce needs to:

- Be culturally competent to provide culturally safe care.
- Have the suitable clinical skills and flexibility to deal with the complex health needs of communities.
- Recognise, value and support Aboriginal staff.
- Have effective cultural leadership.
- Be equipped with appropriate resources, including translators, to effectively communicate with patients and their families.

Holistic care
Holistic care is caring for the physical well-being of an individual while also considering the social, emotional and cultural well-being of the individual and the whole community.

Services should consider:

- Holistic approaches which address priorities of community.
- Care across the continuum of health and disease.
- Responding to family, community, cultural and spiritual responsibilities and obligations.
- Traditional healer (also known as Ngangkari) services should be available upon request.

Best practice care
Best practice care reflects both evidence-based medicine and Aboriginal and Torres Strait Islander worldviews on providing suitable care and supports a broader concept of wellbeing.

Services should ensure that:

- Cultural and scientific evidence is used to provide best practice care.
- Services are available, accessible and acceptable.
- Communities are empowered to be involved in determining local healthcare priorities.
- Multi-disciplinary care that supports holistic care is incorporated.
What does it mean to deliver evidence-based cardiovascular services for Aboriginal people

Evidence-based care means that where possible the best available evidence from around the world is used to guide the development and delivery of services. When peer reviewed, published literature is not available, “expert consensus” can be used to guide service provision.

The SA Aboriginal Heart and Stroke Plan is underpinned by an evidenced based approach called ESSENCE. ESSENCE stands for Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people (see box 1).

The ESSENCE Standards have been used in this project to conceptualise the shape and content of the Plan.

The ESSENCE Indicators will be used to measure the success of the implementation of the Plan. The data collection activity has involved development of a profile for South Australia against any ESSENCE measures where data is currently available. This can act as a baseline for any future evaluation.

Box 1: ESSENCE

Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people.

- The ESSENCE Standards articulate existing evidence and guidelines in a clear, coherent form that can be translated into practice. They were developed in 2011-12 and updated in 2014 and outline the minimum, acceptable level of care below which activity should not be permitted to fall (Brown 2015a; Brown 2015b).
- The 62 ESSENCE Standards cover critical cardiovascular conditions including coronary heart disease, stroke, chronic heart failure, rheumatic heart disease and hypertension and focuses on primary prevention, risk identification and management in primary care, and the management of disease in specialist, acute care and post-acute care settings.
- Following the establishment of the ESSENCE Standards, a set of ESSENCE Indicators were developed to aid measurement of the standards. There are 16 indicators that represent 33 measures which can be used to monitor quality of services based on delivery of evidence-based care, and 6 outcome indicators with 10 measures which can be used to monitor cardiovascular health outcomes.

At the end of this document there is a matrix that maps all the strategies and enablers in the Plan against the ESSENCE Actions and Measures.
Part 1: Strategies for evidence-based, culturally appropriate cardiovascular services

Evidence-based cardiovascular services, provided in a culturally appropriate way should be provided across the life course and continuum of care to reduce the impact and extent of illness and premature mortality from heart disease and stroke in the Aboriginal community.
Strategies for evidence-based, culturally appropriate cardiovascular services

Stage 1 - Primary preventive care:

What is primary preventive care?
The promotion of healthy lifestyles and disease prevention, the assessment and management of risk and the early diagnosis of disease as part of comprehensive primary health care.

What are we trying to achieve?
Improved access and uptake of evidence based preventive health interventions to reduce future burden of disease.

What is currently happening?
- 40% of Aboriginal people aged 35-44 report having a cardiovascular disease.
- Over 30% of Aboriginal people aged 35-44 report having hypertension.
- Almost 80% of Aboriginal people aged 55 years and over report having a cardiovascular disease.

Health promotion and disease prevention
- There are currently no cardiovascular health promotion or disease prevention programs being run state wide and no chronic disease prevention programs.
- There is some federal and state funding for tobacco control initiatives, however it is time limited.
- There is very limited, uncertain funding for nutrition and physical activity prevention activities, primary led by AHCSA.
- Mental Health programs may be supported under new Primary Health Network funding.
- There is a strong message from community that there should be targeted community awareness campaigns about heart disease and stroke to encourage healthy lifestyles, risk management and primary prevention and ongoing management messages. This should have strong community leadership and use of culturally appropriate approaches.

Cardiovascular risk assessment and management
- There is strong evidence to support of Cardiovascular Risk Assessment and Management with Aboriginal and Torres Strait Islander people.
- Cardiovascular Risk Assessment and subsequent management in Aboriginal Community Controlled Health Services is limited. There will be a new Cardiovascular Risk Assessment indicator added to the nKPI set for Aboriginal Community Controlled Health Services from July 1 2016.
- Cardiovascular Risk Assessment and subsequent management in state funded Aboriginal Health Services and private general practice is unknown but is likely to be low given Adult Health Check data (15% of adults had an Adult Health Check recorded).
- Blood pressure and cholesterol checks, as independent risk markers, are being undertaken in some primary care settings but management levels are unclear.
- Most community members have little knowledge of the existence or benefits of cardiovascular risk assessments.
- Given the early onset of established disease, efforts should focus on cardiovascular risk assessment from age 15.
- Cardiovascular risk assessment and management has been a successful focus of work in the Northern Territory.
### Strategy: Primary preventive care

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<tr>
<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tbody>
<tr>
<td><strong>Health promotion and disease prevention</strong></td>
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#### 1: Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s

Develop an awareness and prevention campaign for heart, stroke, and diabetes. This must:
- focus across the life course, with specific approaches for different age groups.
- have key components on physical activity, nutrition, smoking and mental health.
- be coordinated with other appropriate prevention programs as part of a holistic, culturally appropriate approach to health and wellbeing.
- use the story of survivors, and consider the use of narratives to convey the key health messages.
- be aligned with the Strategy for Type 2 Diabetes Mellitus in Aboriginal people in SA.

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<th>SAAHP</th>
<th>PHNs</th>
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<tr>
<td></td>
<td>SA Health Public Health Branch Community Heart Foundation RFDS</td>
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</table>

#### Risk assessment and management

#### 2: Increase the use of cardiovascular risk assessment and management

Support uptake through the development of a model of care, including protocol, toolkit and implementation plan. This must:
- facilitate assessment in people aged 15 years and over at least once every year, as part of Adult Health Check.
- support timely, appropriate management of risk and established disease, including lifestyle advice, support and long-term pharmacological and non-pharmacological treatment.
- integrate management into a holistic approach to care.
- support referral to primary care, acute sector, specialist services and allied health care services including pharmacy.
- outline integration into key elements of practice management, such as patient information management systems, workforce requirements and continuous quality improvement.
- support approaches to improve access, including bulk billing and transport support.
- be developed through coordination between all primary health care providers, allied health, and pharmacies.

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<th>PHNs</th>
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<tr>
<td></td>
<td>AHCSA ACCHOs SA health funded services PHN funded services Private sector GPs NVDPA Heart Foundation Stroke Foundation RFDS</td>
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</tbody>
</table>
Strategies for evidence-based, culturally appropriate cardiovascular services

Stage 2 - Clinical suspicion of disease:

What is clinical suspicion of disease?
Timely diagnosis of heart disease and access to specialist services as close to the individual's home as possible.

What are we trying to achieve?
Improved access to services to identify disease or markers of as early as possible.

What is currently happening?
- As at December 2015 58% of severe, and 71% of moderate ARF/RHD patients received regular echocardiography screening within guideline recommended timeframes.

Diagnostic investigation services
- MBS records of receipt of diagnostic investigation and technical services are the only records available and are not routinely aggregated by Aboriginal status.
- The far north and far west of the state have very limited access to diagnostic investigation and technical services, however a significant Aboriginal population who are likely to need heart and stroke services live in these regions.
- The northern and western suburbs of metropolitan Adelaide have limited access to the medical imaging services however a significant Aboriginal population who are likely to need heart and stroke services live in these regions.
- There has been limited integration of diagnostic services into ACCHOs servicing rural and remote communities.
- Country Health SA, through the iCCnet support, some Point of Care Testing devices (POCT).
- There is limited access to diagnostic investigative services and follow-up care for TIA patients in country SA. There are very few MRI facilities in country SA.

Specialist services
- Specialist physicians play a role in facilitating access to diagnostic services for cardiac conditions.
- There is poor coordination of specialist service across the state with multiple providers and significant overlap in some regions and very limited access to specialist services in other regions.
- There is a lack of specialist services in relation to need in:
  - western and northern Adelaide suburbs;
  - far north and far west of South Australia.
- There is a lack of coordination between GP, specialist and investigative services and fragmented specialist care post discharge.
- Specialist services are not routinely linked to all ACCHOs and specialist services are not always culturally appropriate.
- Patients are unable to routinely access transport to attend specialist outreach services not funded by SA Health.
**Strategy: Clinical suspicion of disease**

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<th>Strategy detail</th>
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<th>Partners</th>
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<tbody>
<tr>
<td>Diagnostic investigation services</td>
<td>SA Health</td>
<td>iCCnet, LHNs, AHCSA, PHNs, ACCHOs, RFDS, RDWA</td>
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</table>

### 3: Provide timely access to non-acute diagnostic services to identify and manage disease

Develop and implement a model of care and referral pathways for non-acute investigations for suspected coronary heart disease, transient ischaemic attack, management of acute rheumatic fever/rheumatic heart disease and chronic heart failure. This must:

- include electrocardiography, echocardiography, coronary angiography, chest x-ray, MRI brain scan, haematology, stress test, ambulatory blood pressure and holter tests.
- outline what should be provided across SA, based on geographic accessibility and burden of disease across the population.
- consider appropriate definitions of ‘accessible’ within appropriate timeframes.
- be developed through a central coordinating body.
- be integrated with electronic patient information management systems.
- integrate information and communications technology solutions to improve clinical information sharing, including POCT and videoconferencing.

### Specialist services

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<tr>
<th>Specialist services</th>
<th>SA Health &amp; RDWA</th>
<th>iCCnet, LHNs, AHCSA, PHNs, ACCHOs, RFDS</th>
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</table>

### 4: Establish a coordinated state wide specialist outreach service

Develop a coordinated specialist outreach service plan for metropolitan, rural and remote SA. The plan must:

- provide on-the-ground cardiac, stroke, allied health and nurse specialists across the State to deliver specialist care for stroke, acute rheumatic fever/rheumatic heart disease, chronic heart failure, coronary heart disease, and atrial fibrillation.
- provide ongoing specialist support and upskilling to primary health care providers, including General Practitioners, nurses and nurse practitioners, and Aboriginal Health Workers.
- integrate information and communications technology solutions including teleconferencing and videoconferencing to supplement usual face-to-face consultations in rural and remote communities.
- ensure that models of delivery of specialist services are defined by local service needs and current provision of primary care services.
- integrate services into ACCHOs where preferred by that service.
- incorporate follow-up care (Strategy 15).
- be informed by existing mapping of services.
Strategies for evidence-based, culturally appropriate cardiovascular services

Stage 3 - Acute episode care:

What is acute episode care?
Equitable access to the best and most reliable acute health care possible, which delivers high quality, well configured, patient centred services in hospital and on route to hospital.

What are we trying to achieve?
Development of the acute system to ensure the major tertiary hospitals, Port Augusta and Ceduna hospitals provide the best care to Aboriginal heart and stroke patients first time, every time.

What is currently happening?
- After adjusting for different age profiles, Aboriginal people were 60% more likely than non-Aboriginal people to be hospitalised for a principal diagnosis of CVD (July 2010-June 2015).
- From 2006-2012, the RFDS undertook 137 primary evacuations and 424 inter-hospital transfers from SA for people identified as Aboriginal for CVD.

Planned and urgent transfers, and emergency retrieval services
- In an emergency Aboriginal people do not call 000 due to the real and the perceived cost of ambulance use.
- Aboriginal identification of patients is not formally or systematically asked during the emergency phase of their journey.
- Transfer and retrieval processes are not systematically culturally appropriate.
- There is poor coordination between referring and referral hospital.
- Planned appointments for patients from country regions are often haphazard with limited funding for transport.
- There is high need for and low levels of service provision in Port Augusta and the northwest region.
- When considering heart specific services, access to point of care testing for troponin and other relevant diagnosis testing is an issue in some locations if the iCCnet is not involved. With respect to stroke it is difficult to access specialist support in an emergency event.

Acute hospital services
- There is poor coordination of Aboriginal patients into and out of hospital.
- In general the non-Aboriginal workforce is not culturally competent and have limited cultural awareness.
- There is a lack of an Aboriginal workforce in heart and stroke acute care.
- There is poor identification of Aboriginal patients across the system with many reasons given for not asking all patients about their Aboriginal and/or Torres Strait Islander status.
- There is a lack of health, cultural and financial support, including nursing staff that are both culturally and clinically skilled, for patients and families during their hospital visit.
- There are pockets of good practice in-hospital cardiac education and some resources specifically for Aboriginal and Torres Strait islander people but they have not been designed for the South Australian community.
- Perceived racism in hospitals is regularly reported by Aboriginal patients and their families.
- Aboriginal Liaison Units are under resourced and not used efficiently or effectively in all cases.
- There is no specialist stroke acute care in Port Augusta despite high demand.
- There are no Aboriginal-specific state-wide reporting against key indicators for the acute setting.
### Strategy: Acute episode

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<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tbody>
<tr>
<td>Planned and urgent transfers, and emergency retrieval services</td>
<td>Heart Foundation</td>
<td>AHCSA</td>
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<tr>
<td>5: Create awareness of warning signs and symptoms</td>
<td>Stroke Foundation</td>
<td>SAAHP</td>
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<tr>
<td>Provide financial and resource support to the Heart Foundation’s ‘Warning Signs of Heart Attack’ and Stroke Foundation’s ‘FAST’ campaigns in the South Australian Aboriginal community. The campaigns must:</td>
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<td>Federal Govt</td>
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<td>- have messages which are culturally and geographically appropriate.</td>
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<tr>
<td>- be integrated with the broader heart, stroke and diabetes awareness and prevention campaign (see Strategy 1).</td>
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<tr>
<td>6: Improve access to ambulance services through upfront reduction of out-of-pocket cost</td>
<td>SAAS</td>
<td>AHCSA</td>
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<tr>
<td>Explore and develop approaches to reduce the upfront out-of-pocket cost of transport by ambulance for people with significant economic disadvantage. The final approaches must be:</td>
<td>Heart Foundation</td>
<td>SAAHP</td>
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<tr>
<td>- integrated into a systems response.</td>
<td>Stroke Foundation</td>
<td>PHNs</td>
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<td>- supported by the Aboriginal community.</td>
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<td>- promoted throughout the Aboriginal communities in SA.</td>
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<tr>
<td>7: Improve identification of Aboriginal or Torres Strait Islander status at the first point of medical contact</td>
<td>SA Health</td>
<td>iCCnet</td>
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<tr>
<td>Establish and maintain a state-wide system where identification of all Aboriginal patients occurs as early as possible. This will enable appropriate risk and cultural considerations to be incorporated into management, across continuum of care. The system must be:</td>
<td>LHNs</td>
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<td>- integrated into electronic patient information management systems.</td>
<td>SAAS</td>
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<td>- incorporated into workforce training.</td>
<td>RFDS</td>
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<td>- written into care pathways.</td>
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<td>- implemented across SAAS, RFDS, emergency services and departments, and hospitals.</td>
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<tr>
<td>8: Develop and implement an Aboriginal and Torres Strait Islander transfer and retrieval services protocol</td>
<td>SAAS</td>
<td>LHNs</td>
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<tr>
<td>The Aboriginal and Torres Strait Islander transfer and retrieval services protocol must include:</td>
<td>RFDS</td>
<td>AHCSA</td>
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<td>- consent;</td>
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<td>- clinical preparation of the patient;</td>
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<td>- collection of primary care service details;</td>
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<td>- collection of patient history where possible;</td>
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<td>- patient and family education about the health issue and what is about to occur;</td>
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<td>- selection and preparation of the escort;</td>
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<td>- consideration of financial resources for the patient and family;</td>
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<tr>
<td>- consideration of social support for the patient and family.</td>
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<tr>
<td>The protocol should:</td>
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<tr>
<td>- be triggered by identification (see Strategy 7).</td>
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<td>- be implemented in all non-metropolitan services which have patients which are transferred and/or retrieved.</td>
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<tr>
<td>- help facilitate the transfer of information from the hospital of origin to the referral hospital and hence be part of the formal communication system.</td>
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### Strategy: Acute episode

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<th>Strategy detail</th>
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<th>Partners</th>
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<tr>
<td><strong>9a: Maintain and expand coordinated regional system of care from first medical contact to definitive care for acute HEART disease</strong></td>
<td>iCCnet</td>
<td>SA Health</td>
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</table>

Support the expanded implementation of a regional system of care for SA for acute heart disease from first point of medical care to definitive care in a tertiary hospital. The regional system must:

- ensure state-wide network access to timely specialist advice through the iCCnet is continued.
- support implementation of video-conferencing support thrombolysis admission.
- link ACCHOs into the state-wide network access to timely specialist advice through the iCCnet.
- explore feasibility of providing thrombolysis in large remote clinics, with adequate resourcing for training and support for medical and nursing staff.
- provide adequate resourcing to iCCnet to provide POCT equipment, training and support to all country hospitals and key points of medical contact including remote ACCHOs.
- incorporate results from POCT and ECGs into a state-wide electronic database to record, share and store results with specialists and across sites.
- integrate the transfer and retrieval services protocol (Strategy 8).
- be integrated into triaging and coordination processes with referring and receiving hospitals.

### 9b: Maintain and expand coordinated regional system of care from first medical contact to definitive care for STROKE and TIA

Support the expanded implementation of a regional system of care for SA for STROKE and TIA from first point of medical care to definitive care in a tertiary hospital. The regional system must:

- ensure state-wide network access to timely specialist advice through the 24/7 stroke specialist phone service.
- integrate the 24/7 stroke specialist phone service into SAAS MedStar service.
- support implementation of video-conferencing support thrombolysis admission.
- link ACCHOs into the state-wide network access to timely specialist advice.
- explore feasibility of providing thrombolysis in Port Augusta and Ceduna, with adequate resourcing for training and support for medical and nursing staff.
- provide adequate training and support to all country hospitals and key points of medical contact including remote ACCHOs, including use of pre-hospital screening tool and triage and retrieval processes.
- support implementation of models of care for stroke and TIA patients in rural and remote locations.
- incorporate results from MRIs into an electronic system to enable access to films for decision making.

SA Health (TH)  
SAAS MedStar  
RFDS  
LHNs
### Acute hospital services

**10a: Develop RAH, FMC, LMH, TQEH, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal HEART clinical and cultural care**

Develop hospitals with the largest throughput of Aboriginal HEART patients to be nationally recognised for Aboriginal HEART clinical and cultural care.

Effective delivery of care should include:
- identification of all Aboriginal patients.
- care delivered in a culturally appropriate manner.
- timely access to emergency care by a competent clinician.
- timely access to reperfusion therapies appropriate to the resourcing at that site, with systems to facilitate transfer within a coordinated regional system, within the index admission.
- specialist cardiac care units with dedicated staff and appropriate treatment capacity to that hospital.
- all cardiovascular clinical staff achieving cultural competence including ED, cardiac and outpatient services.
- adequate resourcing of Aboriginal Liaison Units to work with ward staff and support Aboriginal patients, escorts and family members.
- in-hospital communication to ensure that all patients, and their family and community are informed and have control about the care received.
- in-hospital education to ensure that all patients receive education using culturally relevant resources, with involvement of family members.
- Established referral systems to primary health care and rehabilitation services.

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<th>Hospital and LHNs</th>
<th>SA Health Heart Foundation</th>
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**10b: Develop RAH, FMC, LMH, Berri, Mount Gambier, Whyalla, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal STROKE clinical and cultural care**

Develop hospitals with the largest throughput of Aboriginal STROKE patients to be nationally recognised for Aboriginal STROKE clinical and cultural care.

Effective delivery of care should include:
- identification of all Aboriginal patients.
- care delivered in a culturally appropriate manner.
- timely access to emergency care (including imaging) by a competent clinician.
- timely access to thrombolysis for ischaemic stroke.
- systems to facilitate timely transfer within a coordinated regional system, within the index admission.
- specialist stroke units with dedicated staff and appropriate treatment capacity to that hospital.
- all cardiovascular clinical staff achieving cultural competence including ED, neurology, rehabilitation and outpatient services.
- adequate resourcing of Aboriginal Liaison Units to work with ward staff and support Aboriginal patients, escorts and family members.
- in-hospital communication to ensure that all patients, and their family and community are informed and have control about the care received.
- in-hospital education to ensure that all patients receive education using culturally relevant resources, with involvement of family.
- Established referral systems to rehabilitation services and ongoing care.

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<tr>
<th>Hospital and LHNs</th>
<th>SA Health Stroke Foundation</th>
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</table>
11: Establish an Aboriginal heart and stroke nursing coordinator position at RAH, FMC, LMH, Port Augusta Hospital and Ceduna Hospital to support Aboriginal patients and their families throughout their journey of care

These roles should be adapted to meet the particular needs of that hospital. The role of the coordinator must:
- be focused on case management and coordination of services.
- ensure adequate pre-operative planning and support.
- ensure in-hospital support for patient and their families, and facilitate communicate and education.
- support pre-discharge planning, development of a discharge plan and communication of discharge plan to primary health care services.
- implement models of care in-hospital to improve cultural competent care.

SA Health

12: Develop standard reporting across the state against key performance indicators

Collect, collate and undertake reporting on outcomes by Aboriginal status. The monitoring must:
- be undertaken by all cardiac and stroke service providers and surgical units.
- report on patient characteristics, clinical features, interventional procedures, intra- and post-operative outcomes, 30 day readmission, mortality rates and adverse outcomes.
- be based on national reporting standards.
- have integrated feedback loops to each site.
- be held in a centralised register.

Hospital
LHNs
SA Health
Strategies for evidence-based, culturally appropriate cardiovascular services

Stage 4 - Ongoing care:

What is ongoing care?
Optimisation of transitions of care out of hospital, rehabilitation, and the provision of ongoing preventive care.

What are we trying to achieve?
A system that connects patients leaving the acute sector with high quality ongoing, accessible care including rehabilitation.

What is currently happening?
- Between January 2013-December 2014, 25 Aboriginal people received a referral to cardiac rehabilitation as an in-patient (28%), compared to 34% of non-Aboriginal people.
  - 75% of Aboriginal people eligible for cardiac rehabilitation were under 65 years old, compared to 47% of non-Aboriginal people.
  - 6 Aboriginal people who were referred to cardiac rehabilitation completed (24%). This was slightly higher than the non-Aboriginal rate.

Hospital discharge planning and follow-up
- Pre-discharge education and discharge planning are either not being done or are done poorly and rarely consciously include family members.
- Follow up with Primary Care Services is limited and patients often fall through gap during this transition phase and are lost to follow up post discharge.
- Medications are usually only provided for one week and patients are usually billed for medications.
- Hospitals cannot issue “Close the Gap” prescriptions. This leads to confusion and frustration with eligible patients and creates a barrier to ongoing medication adherence.
- If a patient is transferred or retrieved from a country hospital as an inpatient, and discharged from the tertiary hospital, there is no funding or support through PATS to return home.
- There is a lack of specialist follow-up for cardiac patients.
- There are difficulties accessing stroke rehabilitation specialists in country.

Rehabilitation, secondary prevention and ongoing care
- Cardiac rehabilitation completion rates are low.
- Cardiac rehabilitation referral rates are low but once Aboriginal patients commence a Cardiac rehabilitation programs their completion rates are higher than that of non-Aboriginal people.
- Cardiac rehabilitation services are not culturally or age specific for Aboriginal people.
- Stroke rehabilitation is not culturally or age specific for Aboriginal people.
- There are limited community based culturally appropriate prevention activities for patients to access post discharge.
- There are some overlaps and gaps in primary health care services in both metropolitan and country areas that provide ongoing management and support services.
- PHNs are funding some successful programs that engage with community members across SA and especially in Northern Adelaide.
## Hospital discharge planning and follow-up

### 13: Develop systems to provide patient centred and safe discharge from hospitals

A State-wide model of care should be developed to guide patient centred, safe discharge processes from hospital. Each hospital should develop a site-specific protocol based on the model of care. The model of care must incorporate:

- engagement with patient and family members in planning.
- involvement of Aboriginal Liaison Unit/Aboriginal support services.
- the predicted need for follow-up specialist care.
- access to funded transport to home.
- access to 30 days of medication free of charge to all Aboriginal and Torres Strait Islander patients - this should be co-ordinated with the Close the Gap script subsidies available through Medicare/PBS.
- central referral to primary care and rehabilitation.

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<td>PHNs</td>
<td>SA Health</td>
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<td>Hospitals</td>
<td>PHC services</td>
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Establish a web based central referral system through the iCCnet to enable effective and timely clinical communication and handover occurs following discharge. The service using predominantly telephone follow-up must facilitate:

- a discharge summary reaching primary care provider within 48 hours post discharge.
- A patient follow-up visit at the preferred primary health care service 7-10 days post discharge.
- scripting of medication by primary health care provider.
- referral to an appropriate rehabilitation program chosen by patient (inpatient, outpatient, community-based or rehabilitation in the home).
- GP referral to multidisciplinary specialist and support services and use of a GP Management Plan and Team Care Arrangements.

The referral system should have test-and-learn cycles integrated into implementation.

## Rehabilitation, secondary prevention and ongoing care

### 15: Establish culturally appropriate, evidence based cardiac and stroke rehabilitation services

Review existing models cardiac and stroke rehabilitation, and develop models of care for culturally appropriate services for Aboriginal clients. The models must:

- ensure coverage across metropolitan, regional and remote SA.
- ensure all clients have timely access to services (8 weeks post-discharge).
- support client choice in mode of rehabilitation through multiple models, including one-to-one, group, and telephone/virtual programs.
- ensure cardiac rehabilitation services cover core components in a service.
- involve the family, specialist, primary health care practitioner.

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<td>PHNs</td>
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</table>
Strategies for evidence-based, culturally appropriate cardiovascular services

Services that span the continuum of care

What are services that span the continuum of care?

Strategies that have relevance across the health care system from prevention to ongoing care.

What are we trying to achieve?

Enhancing services that have touch points across the continuum of care helps facilitate a connected network approach to service provision.

What is currently happening?

- 36% of Aboriginal South Australians report having three or more long term health conditions.
- Almost 30% of all SA Aboriginal people live in the far north or far west of SA.
- Aboriginal people are 36 times more likely to be hospitalised for ARF, and 60% more likely to be hospitalised for RHD (July 2005 – June 2015).

Primary Care

- There are currently many providers in the primary care space and a variety of funding and service models being implemented (ACCHOs, SA Health funded services and private practice).
- About 50% of Aboriginal people access comprehensive primary care services that are provided by Aboriginal Community Controlled Health Services. Access to community controlled services is not possible in areas of metropolitan Adelaide and country SA. SA Health funded services provide services in these gaps however their services are restricted.
- While chronic disease is a priority cardiovascular is not overtly prioritised.
- PHNs are funded to commission programs that provide patient coordination and support.
- Private General Practice, that are Practice Incentive Payment-Indigenous Health Initiative approved and aligned with allied health services including pharmacy, are being utilised by Aboriginal people particularly in the western suburbs of Adelaide.

Statewide Regional Network

- The iCCnet run a network that provides timely access to specialist advice in an emergency. Their service has expanded to include cardiac rehabilitation and ongoing management.
- Statewide stroke services are networked through a physician network and the country stroke units based at Whyalla, Berri and Mount Gambier.
- The SA Cardiac Clinical Network and SA Stroke Clinical Network formally ceased in 2015.
- Acute Coronary Syndrome (ACS) and Stroke are priorities in Transforming Health.

RHD Control Program

- SA Health coordinates the SA Rheumatic Heart Disease Control Program. This program currently has federal government funding and is linked to the RHD Australia network. It was a high functioning steering committee that includes all key stakeholders, a robust register with over 200 active cases and a core staff team that facilitate training and support.
- SAHMRI is undertaking a RHD prevalence study (SACRHD) in selected schools, recruiting 2000 kids.
## Strategy: Spanning the continuum of care

### Strategy detail

| 16: Improve access to culturally appropriate comprehensive primary health care services |
|---|---|---|
| Review and reorient, if necessary, current mechanisms to improve access to primary care services for Aboriginal clients. The review should consider: |
| - co-ordinating cardiovascular care across the continuum of disease, including prevention, risk assessment and management, ongoing management of established disease, and palliative and end of life care. |
| - improving access to multidisciplinary specialist and support services. |
| - supporting clients and their families to facilitate appointments, provide transport support, and minimising out-of-pocket costs. |
| - Improving utilisation of funding mechanisms to support improved access by Aboriginal clients. |
| - Increasing utilisation of video-conferencing and information and communications technology solutions where appropriate. |
| Responsibility | PHNs |
| PHCs services | AHCSA |
| SA Health |

| 17: Develop a state-wide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks. Port Augusta should host a regional coordination centre that coordinates and enhances services for Aboriginal people in the far north and west of SA. |
|---|---|---|
| The state-wide model must facilitate delivery of the following services: |
| - outreach diagnostic and management clinics (Strategy 4). |
| - 24/7 Acute specialist advice (Strategy 9, 10). |
| - referral pathways and clinical guidelines for acute event assessment, transfers, specialist referrals and follow-up care (Strategy 8,9,10,12,14,15). |
| - in-patient cardiac and stroke coordinator (Strategy 12). |
| - formalised links between acute and primary health care providers and allied health practitioners (Strategy 15,17). |
| - structured rehabilitation programs (Strategy 16). |
| - data collection and reporting systems (Monitoring & evaluation). |
| - integrated use of information and communications technology solutions (Information & communications technology solutions). |
| - coordination of transportation (Transport support). |
| - standard medication kits, protocols and stock management systems for acute patients at regional and remote centres. |
| - improved feedback and reminder systems to support clinicians (Strategy 14, Information & communications technology solutions). |
| - service planning and clinical leadership (Governance & systems coordination). |
| - regular training and competencies for clinical staff (Workforce development). |
| - reviews and evaluations of processes, costs and outcomes (Monitoring & evaluation). |
| - support systems for GPs providing rehabilitation care (Strategy 15). |
| Responsibility | All |
| PHNs |

The Port Augusta coordination centre must guide coordination of services as outlined above for the far north and west, with implementation of on-the-ground, local services in rural and remote communities.
**18: Maintain and expand of the existing RHD Control Program**

The SA Rheumatic Heart Disease Registry should be expanded to become a full control program including the following elements:

- continued commitment from national, regional and local services to ensure long-term funding and governance support.
- an effective advisory committee.
- ongoing coordinating team.
- an electronic patient register that contains data elements that support quality patient management and reporting requirements.
- prioritisation of primary and secondary antibiotic prophylaxis delivered within the framework of primary healthcare.
- a stable supply of BPG.
- the ability to find new cases of ARF and RHD and to assess and monitor the burden of disease.
- partnerships between clinicians and public health services to support the needs of people with ARF/RHD and the community.
- provision of education for health practitioners and health workers, and supported health education for the community, those with disease and their families.
- activities guided by locally relevant, evidence-based guidelines
- notification of ARF/RHD supported by public health surveillance activities.
- a priority system to service those at highest risk.
- a mechanism for monitoring delivery of secondary prophylaxis and ongoing care.
- evaluation of patient management and program activities.
- development of a single rheumatic valvular surgery centre of excellence in SA.

| SA Health Commonwealth Govt | AHCSA PHNs ACCHOs |
Part 2: Essential enablers for effective strategy

There are key activities within the health care system that are critical to the successful delivery of evidence-based, culturally appropriate cardiovascular services.

These essential ‘enablers’ often span across the health care system, are outside the direct responsibility of cardiovascular services.
Essential enablers for effective strategy

Enabler 1 - Governance and systems coordination

What is governance and systems coordination?
There is a need for an independent, governance structure to drive the implementation and evaluation of the plan and to facilitate system coordination. The governance group must include all agencies that have key responsibilities in the plan and consumers.

What are we trying to achieve?
A governance structure that can drive system change and improvements in heart and stroke outcomes for Aboriginal people in South Australia while also incorporating Aboriginal leadership.

What is currently happening?
- Nationally, in 2014 the Better Cardiac Care for Aboriginal and Torres Strait Islander people project (BCC) lead a focus on improving Aboriginal cardiovascular health. This was developed by the Australian Health Ministers’ Advisory Council (AHMAC) and all states asked to implement BCC in their state. There has been varying progress across states. There is a BCC monitoring system in place through the Australian Institute of Health and Welfare.
- The Australian Commission on Safety and Quality in Health Care (ACSQHC), in partnership with the Australian, state and territory governments, is leading and coordinating national improvements in safety and quality in health care. The ACSQHC are responsible for the National Safety and Quality Health Service Standards (NSQHSS), against which all hospitals require accreditation. Version 2 of the Standards to be released in 2017 will have actions specific to systems change to improve outcomes for Aboriginal and Torres Strait Islander people.
- In South Australia,
  - The South Australian Aboriginal Health Partnership (SAAHP) is the lead group bringing together the State and Commonwealth Governments and the Aboriginal Community Controlled Health Sector to improve Aboriginal health and wellbeing outcomes in South Australia.
  - SA Health through the Transforming Health Project is driving a major effort to develop a systematic approach to ensure all South Australians have equitable access to the best and most reliable health care possible. An Indigenous Working group is soon to be formed and Professor Alex Brown, chair of the Steering committee for this SA Aboriginal heart and Stroke Plan, will lead this group and he sits on the Transforming Health Ministerial Clinical Advisory group (MCAG).
  - The SA Academic Health Science and Translation Centre, a NHMRC funded Centre that has members including SAHMRI, SA Health, AHCSA, both PHNs, all Universities, the Consumer Health Alliance and the Cancer Council seeks to continuously enhance the rate of translation of research into health care in order to create a self-improving and high quality health system, which is sustainable. Aboriginal Health is a research priority of this centre.
  - With the dissolving on the Cardiac and Stroke Statewide Clinical Network in 2015 there is no focused governance framework that currently exists to drive reform on improvements in heart disease and stroke for Aboriginal people in the SA.
### Enabler strategy: Governance and systems coordination

<table>
<thead>
<tr>
<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tbody>
<tr>
<td><strong>1: Develop an SA Aboriginal Heart and Stroke Plan leadership group</strong></td>
<td>SA Academic Health Science and Translation Centre</td>
<td></td>
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</tbody>
</table>
Essential enablers for effective strategy

Enabler 2 - Sustainable funding

What is sustainable funding?
The allocation of adequate, long-term funding with in the health system to deliver safe, effective, efficient care.

What are we trying to achieve?
Sustainable funding for the implementation of plan that will include service provision, governance and coordination, evaluation and the reorientation of practice and prioritisation of existing services.

What is currently happening?
- There are multiple funding sources for Aboriginal health care across all sectors, from Federal and State budgets.
- New reforms, such as those occurring with Medicare, My Aged Care, and Primary Health Networks, demonstrate the ever-changing, complex nature of the financing of the South Australian health care system.
- The Close the Gap program and project funding has seen significant investment over the last 6 years but has the future is uncertain.
- Ongoing funding is largely through mainstream funding bodies, such as MBS and hospital funds. Within these mainstream funding streams, there are ‘loadings’ for services to provide care to Aboriginal people, recognising the complexity of disease and care required.
- Current funding initiatives include MBS items including Aboriginal and Torres Strait Islander Adult Health Check (Item 715) GP Management Plan (Item 721) Team Care Arrangements (Item 723) – and the Close the Gap (CtG) Practice Incentive Payment Indigenous Health Initiative (PIP-IHI) that support GP’s to register their practices and provide CtG prescriptions to CtG registered patients that attract funding subsidies in community based pharmacies.
- Much of the project or program funding which supports Aboriginal people at risk of or with heart disease and stroke is short term. This results in short-term interventions which have insufficient time to demonstrate outcomes. Often, delayed re-funding of short-term programs results in uncertainty and difficulties in maintaining a workforce.
- There is often fragmentation in programs due to overlaps in funding and short-term cycles of programs.
- There are barriers to accessing funding streams. For example, there are restrictions on what services can access funding (such as Close the Gap scripts, MBS funding). This contributes to confusion for both providers and community members on how to access funding streams, and a disengagement from the system. It also contributes to the apparent under-utilisation of funding streams.
- There is a lack of control by community over the use of available funds. This results in disengagement and lack of community commitment to programs.
<table>
<thead>
<tr>
<th>Enabler strategy – Sustainable funding</th>
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<tr>
<td><strong>Strategy detail</strong></td>
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<tr>
<td><strong>2: Develop a business case and funding proposal for the Plan</strong></td>
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<tr>
<td>The leadership committee must develop a comprehensive business case and funding proposal for the Plan. This should be commence July 2016.</td>
</tr>
<tr>
<td><strong>3: Improve uptake and efficiency of already funded initiatives</strong></td>
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<tr>
<td>The leadership committee should support the increased uptake and efficiency of already funded initiatives. The group must consider and advocate for modifications to improve effective access to and use of services. Funding initiatives that should be included are:</td>
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<tr>
<td>- MBS items</td>
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<tr>
<td>o Aboriginal and Torres Strait Islander Adult Health Check (Item 715).</td>
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<td>o GP Management Plan (Item 721).</td>
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<td>o Team Care Arrangements (Item 723).</td>
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<tr>
<td>- Hospital loading for Aboriginal patients.</td>
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<td>- Closing the Gap programs.</td>
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<tr>
<td><strong>4: Commitment to writing into agreements sustainable program and evaluation funding</strong></td>
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<tr>
<td>Agreements should support programs which:</td>
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<tr>
<td>- are culturally appropriate.</td>
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<td>- are evidence based.</td>
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<tr>
<td>- are driven by communities, located in communities, and increase local capacity.</td>
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<td>- have integrated evaluation.</td>
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</table>
Essential enablers for effective strategy

Enabler 3 - Workforce development

What is workforce development?
The provision of a health workforce which has the clinical and cultural competence to provide safe, evidence based care to clients.

What are we trying to achieve?
A workforce which is clinically and culturally competent in providing care to Aboriginal people, through:

- employing more Aboriginal people across all levels of the health workforce so that Aboriginal people play a key part in the design and delivery of health services, and;
- developing the cultural competence of the wider health workforce.
- improving clinical capacity to prioritise identification and management of cardiovascular disease.

What is currently happening?
- Across the health workforce in South Australia, there is insufficient numbers of Aboriginal workforce. This is demonstrated by SA Health only achieving 50% of their target workforce. Having insufficient Aboriginal workforce impacts on the care received by Aboriginal people within the health care system. This is compounded by the lack of a culturally competent non-Aboriginal workforce.
- The non-Aboriginal workforce across multiple sectors of health care clearly lacks culturally competency, including primary health care, diagnostic investigations and specialist services, and hospital services. The lack of cultural competency in the workforce contributes to the continuation of systemic, institutional racism, limited or delayed interaction with the health care system by individuals, increased self-discharge, and disparities in receipt of care and disparities in health outcomes.
- There are individuals within all sectors which demonstrate cultural competency, however these are the exception, not the norm. There are also examples across sectors which have established frameworks for cultural competence, particularly Aboriginal Medical Services and selected wards within hospitals.
- Mainstream staff in the health system:
  - are generally unaware of the extent and impact of heart disease and stroke on the Aboriginal community, especially with respect to the early age of disease onset, and
  - do not prioritise the identification and management of heart disease and stroke.
- There are difficulties in attracting (general and cardiovascular-specific) health practitioners to geographic areas with high need. This is particularly true in the far north and west of SA. There is a specific issue around access to outreach specialist services in northern and north-west Adelaide and the far north and west of SA.
### Enabler strategy: Workforce development

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<tr>
<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tr>
<td><strong>5: Introduce mandatory cultural competence training of all cardiovascular health care providers</strong></td>
<td>SA Health PHNs ACSQHC RACGP ACN</td>
<td><strong>SA Health</strong> <strong>PHNs</strong> <strong>ACSQHC</strong> <strong>RACGP</strong> <strong>ACN</strong></td>
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Introduce a mandatory requirement that all cardiovascular health care providers in South Australia demonstrate cultural competency. This includes primary health, allied health, specialist outreach specialist, emergency, acute and rehabilitation services.

Training should include:
- Aboriginal pre-colonisation and post-colonisation history, including history of dispossession.
- the experiences of Aboriginal clients receiving cardiovascular care
- relationships in Aboriginal communities.
- diversity in Aboriginal cultures.
- what culturally appropriate services are.
- guidance on how to provide culturally competent care.
- basic language (appropriate to the region).

Demonstration of cultural competency should be ongoing. All services should have access to cultural mentors.

| **6: Increase the Aboriginal workforce** | **AHCSA** **SA Health** **PHNs** **ACSQHC** **RACGP** **ACN** **CSANZ** |

Develop targeted approach to increase the Aboriginal health workforce. This should:
- be across all sectors of care including medicine, nursing, allied health, and Aboriginal health practitioner training.
- identify approaches to increase numbers of Aboriginal people undertaking training in ‘mainstream’ and Aboriginal-specific career pathways.
- Build on SA Health Aboriginal employment and workforce strategy.

| **7: Improve access to workforce in western and northern Adelaide, and the far west and north of South Australia** | **SA Health** **PHNs** **AHCSA** **RDWA** |

Develop and implement strategies to improve access to the workforce in areas of need, particularly western and northern Adelaide, and the far west and north of South Australia. This needs to include GPs, nurses, allied health workers and cardiologists.

Efforts must include:
- the training and education sector.
- improved employment incentives.

| **8: Increase awareness of health professionals about the extent and impact heart disease and stroke** | **Heart Foundation Stroke Foundation** **AHCSA** **PHNs** **SA Health** **AMA** **RACGP** **CSANZ** **SSA** **ACN** **ACNC** **RDWA** **ACEM** **APA** |

This should be:
- based on the data from the SA Aboriginal cardiovascular health profile.
- convey the devastating impact heart disease and stroke has on community.
- note that it can be significantly reduced through the application of evidence based strategies and treatment.
- be included in sector-specific competency training, such as risk assessment and management in primary health care.
Essential enablers for effective strategy

Enabler 4 - Transport support

What is transport support?
The provision of appropriate and timely transport to Aboriginal people experiencing socio-economic disadvantage, to access care.

What are we trying to achieve?
All Aboriginal people are able to safely access health care for heart and stroke, regardless of where they live or their socioeconomic status.

What is currently happening?
- Many community members, both in metropolitan Adelaide and rural and remote communities referred to transport as a barrier to accessing primary health, allied health and specialist services.
- Some services provide transport or provide financial support for transport. This includes community buses, provision of transport by the primary health care services, or funding and organisation of transport through the Primary Health Network. This is usually allocated on a case by case basis.
- SA Health provides some funding for transport support for patients using their services (PATS).
  - There are two types of PATS - Patient Aided Transport (Support patients when they are inpatients moving from hospital to hospital) and Patients Assisted Transport (Support for patients when they need to attend outpatient appointments).
  - Funding provided by PATS for rural and remote clients was identified as inadequate in most instances and confusing.
  - Often the mode of transport covered by PATS is contrary to patient best clinical interest and puts individuals at high risk of re-presenting.
- While the role of escort is recognised as important in patient care, this if often not acknowledged by funding for transport, which fails to cover the cost.
- When considering acute, time critical care, there are a range of services available to all Aboriginal people in South Australia in an emergency but access may be an issue for a range of reasons. Community members and health professionals highlighted issues with the cost of ambulance services which leads to issues of patients not accessing Ambulance services.
- Ambulance Insurance for Aboriginal patients and their families are being funded by some Primary Health Networks in South Australia through their Close the Gap Supplementary Services funding.
- South Australian Ambulance Services currently work with ACCHOs to waive some outstanding Ambulance accounts for Aboriginal patients who are suffering hardship. This is not promoted.
Strategy: Transport support

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<tr>
<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tr>
<td>9: Develop a model of care for patients from country SA, who have transfers or retrieval to Adelaide, to be safely returned to the hospital of origin as an inpatient</td>
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<tr>
<td>- Ensure that all patients have transport that suits their medical condition back to the original referring hospital.</td>
<td>Country Health SA LHN</td>
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<tr>
<td>- The provision of suitable transport must be the responsibility of the Heart and Stroke Coordinator while in the Adelaide based hospital.</td>
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| 10: Review out-of-hospital transport support services across SA, across the continuum of care |
| - Review transport support services in metropolitan Adelaide and rural and remote South Australia. | PHN |
| - The review should acknowledge that transport issues are a significant barrier to accessing primary health care and outreach specialist services across the continuum for Aboriginal people. | |
| - The review will be informed by current activities being undertaken by Country Health SA LHN and PHNs. | |
Essential enablers for effective strategy

Enabler 5 - Information & communications technology solutions

What are information & communications technology solutions?
The application of organized knowledge and skills, including devices, procedures and systems, to solve a health problem and improve quality of lives (WHO, 2016).

What are we trying to achieve?
The use innovations in information & communications technology to overcome existing challenges of providing effective, coordinated heart and stroke care to Aboriginal people in South Australia.

What is currently happening?

- Healthcare reform, challenging productivity targets and increased consumer expectation of the care they will receive is driving the integration of new technologies across Australia’s healthcare system. Innovative technologies have the potential to complement mainstream health care and assist with delivering sustainable care into the community. Innovative technologies can help address specific challenges faced by healthcare including: reducing cost and utilisation; delivering better outcomes in a lower cost environment, and; improving access and the patient experience.

- Innovative technologies including videoconferencing, point of care testing (POCT) and home monitoring devices (BP, weights, pulse oximetry, glucose, temperature and INR) have been shown to complement care.

- There are multiple pilots trialling innovative technology to improve the delivery of care, particularly to rural and remote clients around Australia. Particularly of note is the use of video conferencing to support heart disease related outreach services in the Northern Territory with Aboriginal people. As the efficacy and efficiency of these information and communications technology solutions are demonstrated, there should be core funding made available to enable these solutions to be common practice.

- There has been limited integration of information and communications technology solutions in a systematic manner into models of care in South Australia. One example is a videoconferencing trial with Psychologists in regional and remote SA funded by Rural Doctors workforce Agency (RDWA).

- Country Health SA, through the iCCnet, are utilising a few approaches that are supported by information and communications technology solutions to enhance service delivery. These include Point of Care Testing (POCT) across the state, the CATCH Program where Cardiac Rehabilitation is being delivered by telephone with supporting databases for health professionals and Virtual Coordinated Care (VCC) where patients can be monitored remotely for chronic diseases which then are expedited to a face to face home visit when required.

- There are multiple electronic health systems which offer opportunities for better communication of information across services and sectors. These should be considered as important enablers in providing coordinated care.

- With the future Federal Government investment in “My Health Record”, following the “opt out” pilots in 2017, will here are considerable opportunities to improve the collection, linking and follow-up of patient and their medical records. The Northern Territory has used their unique patient identifier system to deliver strong outcomes linking the acute sector to primary care.
### Strategy: Information & communications technology solutions

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<th>Strategy detail</th>
<th>Responsibility</th>
<th>Partners</th>
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<tbody>
<tr>
<td><strong>11: Identify successful technologies and integrate into models of care</strong></td>
<td></td>
<td>SA Health Country Health SA RDWA ACHSA ACCHOs RFDS</td>
</tr>
</tbody>
</table>

Identify and invest in resources, coordination and systems for innovative technologies to integrate into routine models of care.

Videoconferencing should be considered when:
- no face to face option is available or where it can complement limited face to face visits.
- it prevents unnecessary patient travel.
- whole family is able to participate in patient care.
- specialist support is required by physician or aboriginal health worker.

Home videoconferencing between patient and doctor should be considered.

All clinical information generated needs to be shared amongst all health professionals involved in care.

Funding mechanisms to support innovative technologies needs to identified so that these services become sustainable.

| **12: Support linkages between health records across sectors** | SA Health PHNs AHCSA | ACCHOs SA health funded services PHN funded services Private sector GPs |

Develop an approach to improve the communication between the health records controlled by different sectors of care, centred on the My Health Record.

This should consider issues of security and privacy.
**Essential enablers for effective strategy**

**Enabler 6 - Monitoring and evaluation**

**What is monitoring and evaluation?**
The ongoing review and analysis of progress towards achieving the objectives set with a strategic plan. It should be guided by a monitoring and evaluation plan that links to key indicators.

**What are we trying to achieve?**
A system that monitors and evaluates the SA Aboriginal Heart and Stroke Plan, including:

- measuring progress of specific strategies against targets;
- measuring achievement or otherwise of key indicators;
- providing integrated and direct feedback loops to service providers;
- supporting continual improvement of health care services and systems.

**What is currently happening?**

- There are multiple indicators and monitoring tools relating to Aboriginal health outcomes at the state and national levels, including through the SA Health Performance Council, the Health Performance Framework, Overcoming Indigenous Disparities and Australian Institute of Health and Welfare, specifically through their Better Cardiac Care Report.

- There are limited direct feedback loops using these data reports to identify disparities and initiate improvements in care. The nKPIs, within the Aboriginal Community Controlled sector, are positioned to support feedback to services within a Continuous Quality Improvement process.

- Programs and projects often do not receive adequate funding to enable evaluation and demonstrate their level of effectiveness. This perpetuates short-term funding cycles and fragmentation of programs.

- There are opportunities to facilitate monitoring and evaluation of this Plan through SAHMRI as it is positioned as a research and evaluation resource for South Australia that is formally connected to SA Health.
Strategy: Monitoring and evaluation

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<tr>
<th>Strategy detail</th>
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<tr>
<td><strong>13: Develop ongoing monitoring of all aspects of the Plan</strong></td>
<td>SAHMRI</td>
<td>SAAHP SA Health PHNs</td>
</tr>
</tbody>
</table>

Develop an ongoing monitoring and evaluation of Aboriginal heart and stroke health across SA. The monitoring and evaluation structure must:

- provide systematic against Plan targets to quantify impact.
- provide reports to the Leadership committee.
- be based on the existing evidence-based indicators of ESSENCE and BCC, spanning the continuum of care.
- Develop/improve collection methods for data where there is limited/no existing data.
- use the SA Aboriginal Cardiovascular Health Profile (2016) as a baseline.
### Enablers & activity strategies matrix

#### Service strategies

<table>
<thead>
<tr>
<th>Service strategies</th>
<th>✓ = Aligned</th>
<th>✓ ✓ = Direct Link</th>
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#### Enablers

<table>
<thead>
<tr>
<th>Governance &amp; systems coordination</th>
<th>Sustainable funding</th>
<th>Workforce development</th>
<th>Transport support</th>
<th>Information &amp; communication technology solutions</th>
<th>Monitoring &amp; evaluation</th>
</tr>
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</table>

1. Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s
2. Increase the use of cardiovascular risk assessment and management
3. Provide timely access to non-acute diagnostic services to identify and manage disease
4. Establish a coordinated state-wide specialist outreach service
5. Create awareness of warning signs and symptoms
6. Improve access to ambulance services through upfront reduction of out-of-pocket cost
7. Improve identification of Aboriginal or Torres Strait Islander status at the first point of medical contact
8. Develop and implement an Aboriginal and Torres Strait Islander transfer and retrieval services protocol
9a. Maintain and expand coordinated regional system of care from first medical contact to definitive care for acute HEART disease
9b. Maintain and expand coordinated regional system of care from first medical contact to definitive care for STROKE and TIA
10a. Develop RAH, FMC, LMH, TQEIH, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal HEART clinical and cultural care
10b. Develop RAH, FMC, LMH, Berri, Mount Gambier, Whyalla, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal STROKE clinical and cultural care
11. Establish an Aboriginal heart and stroke nursing coordinator position at RAH, FMC, LMH, Port Augusta Hospital and Ceduna Hospital to support Aboriginal patients and their families throughout their journey of care
12. Develop standard reporting across the state against key performance indicators
13. Develop systems to provide patient-centred and safe discharge from hospitals
14. Develop central referral service that links with primary care, specialist follow-up and cardiac/stroke rehabilitation
15. Establish culturally appropriate, evidence-based cardiac and stroke rehabilitation services
16. Improve access to culturally appropriate comprehensive primary health care services
17. Develop a state-wide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks. Port Augusta should host a regional coordination centre that coordinates and enhances services for Aboriginal people in the far north and west of SA
18. Maintain and expand of the existing RHD Control Program
Alignment of the SA Aboriginal Heart and Stroke Plan strategies to Better Cardiac Care for Aboriginal and Torres Strait Islander people and ESSENCE

<table>
<thead>
<tr>
<th>Service strategies</th>
<th>Better Cardiac Care for Aboriginal and Torres Strait Islander people</th>
<th>Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s</td>
<td>Action 1.3</td>
<td>V.1.1, V.3.1, VI.1.2</td>
</tr>
<tr>
<td>2. Increase the use of cardiovascular risk assessment and management</td>
<td>Action 1.1, Action 1.3</td>
<td>I.2.1, I.2.2, I.2.3, I.2.4, II.1.1, III.1.1, V.3.1, V.3.5, VI.1.1, VI.1.2, VI.1.3, VI.2</td>
</tr>
<tr>
<td>3. Provide timely access to non-acute diagnostic services to identify and manage disease</td>
<td>Action 2.1, Measure 2.1, Measure 2.2</td>
<td>II.1.1, III.1.2, II.2.1, V.2.2, V.3.2</td>
</tr>
<tr>
<td>4. Establish a coordinated state wide specialist outreach service</td>
<td>Action 2.1, Measure 2.3, Measure 4.3</td>
<td>II.1.1, III.3.1</td>
</tr>
<tr>
<td>5. Create awareness of warning signs and symptoms</td>
<td>Action 3.1</td>
<td>I.3.1, I.6.1, II.2.1</td>
</tr>
<tr>
<td>6. Improve access to ambulance services through upfront reduction of out-of-pocket cost</td>
<td></td>
<td>I.3.1, I.6.1, II.2.1</td>
</tr>
<tr>
<td>7. Improve identification of Aboriginal or Torres Strait Islander status at the first point of medical contact</td>
<td></td>
<td>I.6.6</td>
</tr>
<tr>
<td>8. Develop and implement an Aboriginal and Torres Strait Islander transfer and retrieval services protocol</td>
<td>Action 3.2</td>
<td>I.3.1, I.6.1, II.2.1, II.2.3, II.2.4, II.2.5, II.2.6, II.2.7, IV.1.3, IV.1.4</td>
</tr>
<tr>
<td>9a: Maintain and expand coordinated regional system of care from first medical contact to definitive care for acute HEART disease</td>
<td>Action 3.2, I.6.1, I.6.4, II.2.1, II.2.2, II.2.3, III.2.1</td>
<td>Service measure 8a, Service measure 9a, 9b</td>
</tr>
<tr>
<td>9b: Maintain and expand coordinated regional system of care from first medical contact to definitive care for STROKE and TIA</td>
<td>Stroke not included in Better Cardiac Care</td>
<td>I.3.1, I.6.1, I.6.4, IV.1.1, IV.1.2, IV.1.3, IV.1.4, IV.1.5, IV.1.6</td>
</tr>
<tr>
<td>10a. Develop RAH, FMC, LMH, TQEH, Port Augusta and Ceduna hospitals as</td>
<td>Action 3.3, Measure 3.1</td>
<td>I.3.1, I.3.2, I.4.1,</td>
</tr>
</tbody>
</table>

**Service measure**
- 3a, 3b, 3c, 3d
- 4a
- 5a, 5b
- 6a, 6b
- 14a
- 8a, 8b
- 9a, 9b, 9c
- 10a
- 8c
- 9a, 9b
- 9c
- 8c
- 9c
## Service strategies

<table>
<thead>
<tr>
<th>Better Cardiac Care for Aboriginal and Torres Strait Islander people</th>
<th>Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actions</strong></td>
<td><strong>Measures</strong></td>
</tr>
<tr>
<td>services that are recognised for Aboriginal <strong>HEART</strong> clinical and cultural care</td>
<td>Action 4.1</td>
</tr>
<tr>
<td><strong>10b</strong>: Develop RAH, FMC, LMH, Berri, Mount Gambier, Whyalla, Port Augusta and Ceduna hospitals as services that are recognised for Aboriginal <strong>STROKE</strong> clinical and cultural care</td>
<td>Stroke not included in Better Cardiac Care</td>
</tr>
<tr>
<td>11. Establish an Aboriginal heart and stroke nursing coordinator position at RAH, FMC, LMH, Port Augusta Hospital and Ceduna Hospital to support Aboriginal patients and their families throughout their journey of care</td>
<td></td>
</tr>
<tr>
<td>12. Develop standard reporting across the state against key performance indicators</td>
<td>Action 3.3 Action 3.4</td>
</tr>
<tr>
<td>13. Develop systems to provide patient centred and safe discharge from hospitals</td>
<td></td>
</tr>
<tr>
<td>14. Develop central referral service that links with primary care, specialist follow-up and cardiac/stroke rehabilitation</td>
<td>Action 4.2 Action 4.3</td>
</tr>
<tr>
<td>15. Establish culturally appropriate, evidence based cardiac and stroke rehabilitation services</td>
<td>Action 4.4</td>
</tr>
</tbody>
</table>
### Service strategies

#### 16. Improve access to culturally appropriate comprehensive primary health care services

<table>
<thead>
<tr>
<th>Actions</th>
<th>Measures</th>
<th>Standards</th>
<th>Indicator measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action 2.1</td>
<td>Measure 4.2</td>
<td>l.4.2, l.4.5, l.6.2 III.1.1, III.1.2 V.3.2, V.3.4, V.3.6, V.4</td>
<td>Service measure 11b</td>
</tr>
<tr>
<td>Action 4.3</td>
<td>Measure 4.3</td>
<td>l.6.1, l.6.4 IV.1.5</td>
<td>Service measure 14a</td>
</tr>
</tbody>
</table>

#### 17. Develop a state-wide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks. Port Augusta should host a regional coordination centre that coordinates and enhances services for Aboriginal people in the far north and west of SA

<table>
<thead>
<tr>
<th>Actions</th>
<th>Measures</th>
<th>Standards</th>
<th>Indicator measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action 2.1</td>
<td>Measure 4.4</td>
<td>l.6.1, l.6.4 IV.1.5</td>
<td>Service measure 14a</td>
</tr>
</tbody>
</table>

#### 18. Maintain and expand of the existing RHD Control Program

<table>
<thead>
<tr>
<th>Actions</th>
<th>Measures</th>
<th>Standards</th>
<th>Indicator measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action 5.1</td>
<td>Measure 5.1</td>
<td>V.1.1, V.1.2, V.2.1, V.2.2, V.3.1, V.3.2, V.3.4, V.3.5, V.3.6, V.4</td>
<td>Service measure 7a, 7b</td>
</tr>
<tr>
<td>Action 5.2</td>
<td>Measure 5.2</td>
<td>Service measure 15a</td>
<td></td>
</tr>
<tr>
<td>Enabler strategies:</td>
<td>Better Cardiac Care for Aboriginal and Torres Strait Islander people</td>
<td>Essential Service Standards for Equitable National Cardiovascular care for Aboriginal and Torres Strait Islander people</td>
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<tr>
<td></td>
<td>Actions</td>
<td>Measures</td>
<td>Actions</td>
</tr>
<tr>
<td>1. <strong>Develop an SA Aboriginal Heart and Stroke Plan leadership group</strong></td>
<td>Action 2.1</td>
<td>I.6.4</td>
<td>Service measure 14a</td>
</tr>
<tr>
<td>2. <strong>Develop a business case and funding proposal for the Plan</strong></td>
<td></td>
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<tr>
<td>3. <strong>Improve uptake and efficiency of already funded initiatives</strong></td>
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<tr>
<td>4. <strong>Commitment to writing into agreements sustainable program and evaluation funding</strong></td>
<td></td>
<td>I.2.1, I.2.2, I.2.4, I.4.2</td>
<td></td>
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<tr>
<td>5. <strong>Introduce mandatory cultural competence training of all cardiovascular health care providers</strong></td>
<td></td>
<td>I.6.6</td>
<td></td>
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<tr>
<td>6. <strong>Increase the Aboriginal workforce</strong></td>
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<tr>
<td>7. <strong>Improve access to workforce in western and northern Adelaide, and the far west and north of South Australia</strong></td>
<td></td>
<td>I.5.1, I.6.6</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Increase awareness of health professionals about the extent and impact heart disease and stroke</strong></td>
<td></td>
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<tr>
<td>9. <strong>Develop model of care for patients from country SA who have transfers or retrieval to Adelaide to be returned to the referral hospital as an in-patient</strong></td>
<td>Action 5.4</td>
<td>Measure 5.2, Measure 5.3</td>
<td>I.6.3, V.1.1, V.1.2</td>
</tr>
<tr>
<td>10. <strong>Review out-of-hospital transport support services across SA, across the continuum of care</strong></td>
<td></td>
<td></td>
<td>I.3.1, I.6.1</td>
</tr>
<tr>
<td>11. <strong>Identify successful technologies and integrate into models of care</strong></td>
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<tr>
<td>12. <strong>Support linkages between health records across sectors</strong></td>
<td>Action 1.2</td>
<td></td>
<td>I.6.2</td>
</tr>
<tr>
<td>13. <strong>Develop ongoing monitoring of all aspects of the Plan</strong></td>
<td>Action 1.2, Action 3.3, Action 3.4</td>
<td>Measure 6.1, Measure 6.2</td>
<td>I.6.5</td>
</tr>
</tbody>
</table>
References

AHMAC 2014, *National Recommendations for Better Cardiac Care for Aboriginal and Torres Strait Islander People Post-Forum Report*, AHMAC.


## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCHO</strong></td>
<td>An ACCHO is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).</td>
</tr>
<tr>
<td><strong>AHCSA</strong></td>
<td>The Aboriginal Health Council of South Australia (AHCSA) is an ACCHO membership-based peak body with a leadership, watchdog, advocacy and sector support role.</td>
</tr>
<tr>
<td><strong>BPG</strong></td>
<td>Benzathine penicillin G (BPG) injection is the only effective and cost-effective rheumatic heart disease control strategy at both community and population level.</td>
</tr>
<tr>
<td><strong>iCCnet</strong></td>
<td>The Integrated Cardiovascular Clinical Network South Australia (iCCnet CHSA), aims to provide a state-wide provider clinical network which supports the practice of evidence based medicine and continuous quality improvement in the management of cardiovascular disease in diverse settings across regional, rural and remote South Australia. The fundamental aim of iCCnet CHSA is to remove barriers to the access to necessary, safe cardiovascular care and to improve clinical outcomes.</td>
</tr>
<tr>
<td><strong>LHN</strong></td>
<td>A local hospital network (LHN) is an organisation that provides public hospital services in accordance with the National Health Reform Agreement. There are 5 LHNs in SA.</td>
</tr>
<tr>
<td><strong>RDWA</strong></td>
<td>The RDWA provides the workforce to enhance the health and wellbeing of rural communities in SA.</td>
</tr>
<tr>
<td><strong>PATS</strong></td>
<td>The Patient Assistance Transport Scheme (PATS) is a subsidy program that provides money to pay for some travel, escort and accommodation costs when rural and remote South Australians travel over 100 kilometres each way to see a specialist.</td>
</tr>
<tr>
<td><strong>PHNs</strong></td>
<td>Primary Health Networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.</td>
</tr>
<tr>
<td><strong>POCT</strong></td>
<td>Point of care testing are tests performed near or at the site of a patient that will be used to make a clinical decision and to take appropriate action which will help lead to improved health outcomes.</td>
</tr>
<tr>
<td><strong>SAAS Medstar</strong></td>
<td>SA Ambulance Service (SAAS) MedSTAR is South Australia’s single emergency medical retrieval service. Responsible for providing care to the critically ill and injured throughout the SA Health care region and beyond, MedSTAR is committed to providing a world leading emergency medical retrieval service. SAAS MedSTAR utilises road, rotary wing and fixed wing transport platforms. SAAS MedSTAR also performs back transfers of patients to rural and interstate facilities for paediatric and neonatal patients on a regular basis.</td>
</tr>
<tr>
<td><strong>Transforming Health</strong></td>
<td>The State Government is committed transforming our healthcare system to provide the quality care, effectiveness and adaptability that South Australians expect and deserve. Transforming Health this this reform.</td>
</tr>
</tbody>
</table>